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State Experience with Medicaid Managed Long-Term Services and Supports (MLTSS)

Louisiana Long Term Care Advisory Group

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Overview

- Why are states adopting MLTSS?
- Key questions about MLTSS' Impact
- CMS standards for MLTSS program development and design
- State experience with MLTSS
- Importance of State oversight

Why are states adopting MLTSS?

- System Balancing
  - Another strategy to increase use of community services/decrease use of institutional care
- Predictable Cost & Potential Cost Savings
  - Capitation (per member per month) payment set in advance
- Care Coordination
  - Opportunity to better coordinate services
- Better Outcomes
  - Potential to improve quality

Major Questions about MLTSS' Impact

- To what degree does it help rebalance the LTSS system?
- How will it affect access to care and care coordination for enrollees?
- Does it produce equal or better quality of care?
- Does it save costs relative to FFS, and if so how much and under what conditions?
- How will providers be affected?

Does MLTSS Work? A few caveats. . .

- **Strong evidence on impact is thin**
  - Few studies with reliable comparison group(s)
  - Factors other than MLTSS may account for outcomes
- **Effects depend on program design; study findings in one state do not necessarily apply to other states due to differences in:**
  - Enrolled populations; mandatory versus voluntary enrollment
  - Covered services
  - MCO experience with MLTSS
  - State contracts with any qualified plan vs. limited participation
  - Any qualified provider provisions
- **Effects can change over time and influenced by state oversight**

CMS Sets Standards for MLTSS Programs

- **10 MLTSS "Essential Elements" guide CMS' review and approval of State MLTSS programs* (issued May 2013)**

For example:

- **#7. Comprehensive and Integrated Service Package**
  - CMS urges states to make benefit packages through the MCOs as comprehensive as possible. When all services are not covered through the MLTSS plan, states should include contract provisions on coordination and referral to ensure that the beneficiary's service plan is holistic and person-centered.
- **#9. Participant protections**
  - To prevent abuse or neglect, CMS expects states to hold plans accountable through contract provisions specifying appropriate health and welfare assurances, a strong critical incident management system, and an appeals process that allows services to continue while appeals are pending.

* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Summary-Elements.pdf

State Experiences with MLTSS

1) Rebalancing

- **Minnesota** (2011): Highest share (83%) of new Medicaid LTSS users first receiving services in the community
- **Tennessee** (2013): Share of LTC population using HCBS rose from 17% before program implementation to 30% after first year of the program

2) Beneficiary/Family Satisfaction

- **Minnesota** (2004): 92% of MLTSS enrollees were satisfied or very satisfied that they got the help they needed when calling the health plan and 99% would recommend their plan to family or friends
- **Texas** (2011): 63% usually or always had positive experiences accessing care, compared to 78% for Medicaid plans nationally

For full citations see Mathematica memo to Louisiana, 12/10/2013

State Experiences with MLTSS

3) Health Service Utilization

- **Arizona** (1996, 1997): Enrollees less likely than those in New Mexico to have a hospitalization, IP professional visit, lab service and more likely to have evaluation and management visit, ER visit, and medication visit
- **Massachusetts** (2009): MLTSS program reduced risk of entering a NF by 32% over first two years of operation
- **Minnesota** (2004): Program enrollees had significantly fewer hospital days and preventable hospital admissions than the control group
- **Wisconsin** (2005): PCP visits 5.6% more frequent among MCO members than comparison group

State Experiences with MLTSS

4) Access & Care Coordination

- **New York** (2011): Majority indicated providers and services are always or usually on time and reported high satisfaction for quality and timeliness for visiting nurses, HH aides, and PTs.
- **Minnesota** (2013): Before program, implementation (1997), about 9.5% of dual eligibles took advantage of home-based LTC services offered through the Elderly Waiver program. By 2012, that figure increased to nearly 40%.
- **Texas** (2011): 74% of members reported usually or always getting care quickly, compared to the national Medicaid average of 80%.
- **Arizona** (2008): 96% regard their case managers as good, very good, or excellent. 90% say they have provided help quickly and responded promptly to a request for information (93%).

State Experiences with MLTSS

5) Quality of Care

- **Massachusetts** (2011): In 2009, one of the MCOs (Commonwealth Care Alliance) scored in the 90th percentile or above in HEDIS measures for comprehensive diabetes care, monitoring patients on long term medications, and access to preventive services.
- **New York** (2012): 90% of enrollees' functional ability was stable or improved over a 6 or 12 month period; 80% of enrollees were stable or showed improvement in managing oral medication during the follow up period.

State Experiences with MLTSS

6) Cost Savings/Cost Control

- **Arizona** (1996): program was estimated to save 35% of projected nursing home costs
- **Massachusetts** (2011): In 2008, monthly medical costs for disabled MLTSS members were $3,600 versus $5,210 for FFS patients
- **New York** (2011): From 2003 to 2010, cost per MLTSS enrollee increased by only 2.4 percent, compared to per capita costs for FFS beneficiaries receiving HCBS (+40%), and nursing home spending (+18%)
- **Texas** (2009): Combined savings in first 2 years of the program were about $6 million ($4 per member per month)
- **Wisconsin** (2005): Average individual monthly costs for a sample of participants were $452 lower than the comparison group

State Experiences with MLTSS

7) Provider Impacts (2014)

- **Delayed payment frequently the biggest issue**
- **Small providers face more challenges**
  - Lack of required liability insurance or resources to go through credentialing process or to interface with multiple billing systems, inability to absorb short term losses during transition period
- **Some states protect existing providers by requiring MCOs to offer contracts to any qualified provider, at least in initial years** (e.g., nursing homes in DE, FL, TN)
- **Nursing home payment rates protected during first years of roll out in many states** (e.g. DE, TN, and FL, which set nursing home rates equal to state rates and state will continue to set the rates)

State Oversight Matters

- **Contract Monitoring and Performance Goals**
  - Automated tools to ensure MCO reports are submitted, reviewed, and acted upon appropriately
  - Contract revisions to raise performance targets & incentives for exceeding quality standards
- **Provider Network Adequacy**
  - Mystery shoppers to verify that provider offices are open and accepting new patients
- **Quality Assurance & Improvement**
  - Electronic visit verification systems to monitor home care services in real time
  - Dashboard of performance indicators on many dimensions
  - Use of encounter data to construct quality measures

Questions?